IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 31, 2008

Barry Smith, Administrator
Beehive Home Kenmere-Assisted Living Centers, LLC
5521 W Hollilynn Dr
Boise, ID 83709

License #: RC-885

Dear Mr. Smith:

On December 19, 2007, an initial licensure survey was conducted at Beehive Home Kenmere-Assisted Living Centers, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Donna Henscheid, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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Post Office Box 83720
Boise, Idaho 83720-0036
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FAX: (208) 364-1811

December 26, 2007

Barry Smith, Administrator
Beehive Home Kenmere
5521 W Hollilynn Drive
Boise, ID 83709

Dear Mr. Smith:

On December 19, 2007, an Initial Licensure survey was conducted at Beehive Home Kenmere-Assisted Living Centers, Inc. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by January 19, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

Patty Ward-Acree, MSW for
JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R885	A. BUILDING _____ B. WING _____	12/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME KENMERE-ASSISTED LIVING	**2321 N KENMERE DRIVE MERIDIAN, ID 83642**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the initial survey conducted at your facility. The surveyors conducting the initial survey were: Donna Henscheid, LSW Team Coordinator Health Facility Surveyor Diane Schafer, RD, CDE Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor	R 000		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Beehive Home, Kenmere	2321 N. Kenmere Dr.	208-888-5045
Administrator	**City**	**ZIP Code**
Barry Smith	Meridian	83642
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Initial	12/19/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	300.01	The facility RN did not provide nurse delegation to include Foley catheter care, insulin use, and all sublingual medications to caregivers.	1/29/08	DH
2	305.01	The facility RN did not complete an initial assessment of Resident #1's, Room #5's use of side rails/ positioning device.		
3	305.02	The facility RN did not ensure the PRN's as ordered by the physician were available in the facility.	1/29/08	DH
4	310.01.d	The facility unlicensed caregivers assisted Resident #1's level of care and assisted with sublingual medications without direction from the facility nurse.	1/29/08	DH

Response Required Date	Signature of Facility Representative	Date Signed
1/19/08		12/19/07